PRINTED: 06/12/2009
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475037	A. BUILDING _____ B. WING _____	C 06/03/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROWAN COURT HEALTH & REHAB	378 PROSPECT STREET BARRE, VT 05641

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced onsite complaint investigation was completed by the Division of Licensing and Protection on 6/3/09.	F 000		
F 151 SS=D	483.10(a)(1)&(2) EXERCISE OF RIGHTS The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure 1 applicable resident is allowed to exercise his or her rights as a resident of the facility (Resident #1). Findings include: Per record review, Resident #1 was not allowed to make choices about where he/she ate meals. Per the most recent MDS (Minimum Data Set) with an Assessment Reference Date of 5/5/09, Resident #1 was coded as having no problems with short or long term memory, and is independent with decision making. Per a nurses' note dated 4/27/09, after an incident of inappropriate behavior in the main dining room involving Resident #1, "Admin. stated no meals in DR (dining room) as it was a privilege and he had abused his options. To be out of DR until further notice." This behavior modification strategy was not added to the plan of care, and the resident was not allowed to eat with his/her peers until 5/27/09. On 5/28/09 an incident occurred involving objects falling to the floor in Resident	F 151	Tag F 151 Residents # 1 did not have any adverse affects from this alleged deficient practice. Residents # 1 did receive all three meals as required. All residents who present with unacceptable behaviors have the potential to be affected. All nursing staff will be in-serviced on the proper way to deal with unacceptable behaviors. Proper practices will be monitored through random audits of Nurse's Notes with all residents presenting with unacceptable behaviors for 60 days. Said audits to be completed once a week at a minimum. Results of the audits will be reported to the Quality Improvement Committee monthly by the Director of Nurses or designee. The Director of Nurses or designee will be responsible for compliance. The corrective action plan completion date: 6/29/2009 P.O.C. Accepted 6/24/09 Pamela McCotaRN	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 6/22/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 151	Continued From page 1 #1's room. A nurses' note, dated 5/28/09, states "Since then has been told he must eat in his room all meals." Per observation, at 10:03 AM on 6/3/09, a nurse told Resident #1 that "[The Administrator] took your dining room privileges away because of the incident with making a mess in your room..." During an interview on 6/3/09 at 2:00 PM, the resident stated that he "would like to go out and eat with the other people" and stated he was "definitely punished for something that was an accident." Per observation on the day of survey, Resident #1 ate the noon meal in his/her room. Also see F242.	F 151		
F 203 SS=D	483.12(a)(4)-(6) TRANSFER AND DISCHARGE REQUIREMENTS Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more	F 203		

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F 203	Continued From page 2 immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days. The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide a 30 day written notice of involuntary discharge for 1 applicable resident (Resident #1). Findings include: Per record review and staff interview, a 30 day eviction notice was given verbally to Resident #1 on 5/28/09 by the facility Administrator. The	F 203	Tag F 203 Resident # 1 did not have any adverse effects from this alleged deficient practice. All residents who receive a notice of involuntary discharge has the potential to be affected. All administrative personnel will be in-serviced on the importance of making sure any involuntary discharge receives a 30 day notice in a timely basis. Proper practices will be monitored with any further case discussed in morning meeting. Any involuntary discharges will be reported to the Quality Improvement Committee monthly for the next 3 months by the Director of Nurses or designee. The Director of Nurses or designee will be responsible for compliance. The corrective action plan completion date: 6/29/2009 P.O.C. Accepted 6/24/09. Pamela Mercier RN	

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F 203	Continued From page 3 resident was discharged from the facility on 6/4/09. Per interview on 6/3/09 at 11:55 AM, the Administrator confirmed that a written discharge notice was not issued to the resident or legal responsible party.	F 203		
F 242 SS=D	483.15(b) SELF-DETERMINATION AND PARTICIPATION The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and record review, the facility failed to allow 1 applicable resident to make choices about aspects of his or her life in the facility (Resident #1). Findings include: Per record review, Resident #1 was not allowed to make choices about where he/she ate meals. Per the most recent MDS (Minimum Data Set) with an Assessment Reference Date of 5/5/09, Resident #1 was coded as having no problems with short or long term memory, and is independent with decision making. Per a nurses' note dated 4/27/09, after an incident of inappropriate behavior in the main dining room involving Resident #1, "Admin. stated no meals in DR (dining room) as it was a privilege and he had abused his options. To be out of DR until further notice." This behavior modification strategy was not added to the plan of care, and the resident	F 242	Tag F 242 Resident # 1 did not have any adverse effects from this alleged deficient practice. All residents who present with unacceptable behaviors have the potential to be affected. Nursing staff will be in-serviced on the need to follow the care plan as it relates to addressing behaviors. Per telephone call ☎ Jamie Jones, DNS 6/24/09 12:15pm ~~Random audits of care plans weekly for 60 days.~~ Results of the audits will be reported to the Quality Improvement Committee monthly for the next 3 months by the Director of Nurses or designee. The Director of Nurses or designee will be responsible for compliance. The corrective action plan completion date: 06/29/2009 Proper practices will be monitored through random audits of nurses' notes with all residents presenting with unacceptable behaviors for 60 days. Said audits to be completed once a week at a minimum.	

P.O.C. Accepted 6/24/09.
Pamela McotaRN

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F 242	Continued From page 4 was not allowed to eat with his/her peers until 5/27/09. On 5/28/09 an incident occurred involving objects falling to the floor in Resident #1's room. A nurses' note, dated 5/28/09, states "Since then has been told he must eat in his room all meals." Per observation, at 10:03 AM on 6/3/09, a nurse told Resident #1 that "[The Administrator] took your dining room privileges away because of the incident with making a mess in your room..." During an interview on 6/3/09 at 2:00 PM, the resident stated that he "would like to go out and eat with the other people" and stated he was "definitely punished for something that was an accident." Per observation on the day of survey, Resident #1 ate the noon meal in his/her room. Also see F151.	F 242		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		

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F 280	Continued From page 5	F 280		

This REQUIREMENT is not met as evidenced by:
Based on interview, observation, and record review, the facility failed to revise the care plan of 1 applicable resident in the targeted sample (Resident #1). Findings include:

Per record review, the care plan for Resident #1 was not revised to include a behavior modification strategy that restricts Resident #1 to his/her room for all meals. Per a nurses' note dated 4/27/09, after an incident of inappropriate behavior in the main dining room involving Resident #1, "Admin. stated no meals in DR (dining room) as it was a privilege and he had abused his options. To be out of DR until further notice." This behavior modification strategy was not added to the plan of care, and the resident was not allowed to eat with his/her peers until 5/27/09. On 5/28/09 an incident occurred involving objects falling to the floor in Resident #1's room. A nurses' note, dated 5/28/09, states "Since then has been told he must eat in his room all meals." Per observation, at 10:03 AM on 6/3/09, a nurse told Resident #1 that "[The Administrator] took your dining room privileges away because of the incident with making a mess in your room..." Per observation on the day of survey, Resident #1 ate the noon meal in his/her room. At 1:20 PM on 6/3/09, the ADNS confirmed that the care plan did not address the resident having to eat all meals in his/her room.

Tag F 280

Resident # 1 did not have any adverse effects from this alleged deficient practice. All residents who present with unacceptable behaviors have the potential to be affected. Nursing staff will be in-serviced on the need to follow the care plan as it relates to addressing behaviors.

Random audits of care plans weekly for 60 days.

Results of the audits will be reported to the Quality Improvement Committee monthly for the next 3 months by the Director of Nurses or designee.

The Director of Nurses or designee will be responsible for compliance.

The corrective action plan completion date: 06/29/2009

P.O.C. Accepted 6/24/09.
Pamla McotaRN